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Page	Page	Page	Page
ORIGINAL LECTURE.	REPORTS OF SOCIETIES.	THE WEEK:	Medical Society of the County of New York.
Lectures on the Morbid Conditions of the Blood. By Austin Flint, M.D. Lecture IV. 225	N. Y. PATHOLOGICAL SOCIETY: Stated Meeting, June 24, 1863. Dr. I. A. Voss in the Chair. Chronic Pneumonia in a Child, ending in Abscess of the Lung.—Invagination. — Congenital Cancerous Cystic Hygroma. — Morbus Coxarius.—Necrosis of Head of Femur. 280	Operations of the Sanitary Commission in the Western Department. 282 Dr. Christison on Social Science. 282	An Anomaly in Cranial Structure. 285
ORIGINAL COMMUNICATIONS.	EDITORIAL ARTICLES.	REVIEWS.	ARMY MEDICAL INTELLIGENCE.
Operations on the Air-Tube. By Chas. K. Briddon, M.D. 227 Death resulting from the Use of Chloroform during Labor. By O. D. Pomeroy, M.D. 229 Gunshot Wound of Brain. By T. H. Stilwell, M.D. 229	Humanities and Inhumanities of War. 281	Transactions of the Medical Society of the State of N. Y. 282	Applications for Artificial Limbs. 285 General Orders, No. 351. 286 Orders, Changes, etc. 286
		CORRESPONDENCE.	MEDICAL NEWS.
		Joseph Hyrtl, the Anatomist of the Vienna Medical School. 284	METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK. SPECIAL NOTICES.

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LECTURE IV.

*Formation of Coagula in the Heart and Vessels.—Embolia.
—Thrombosis.—Morbid Conditions relating to Albumen.
—Diminution of Albumen in Albuminuria.—Relations of
this Condition to Dropsy.—Morbid Conditions relating to
Water in the Blood.—Hydræmia.*

Thus far reference has been had chiefly to coagulation of the blood withdrawn from the body. It may take place in the body, *first*, after having been effused, *i. e.* outside of the vessels, and, *second*, within the vascular system. Blood extravasated into serous cavities, upon mucous surfaces, and into the substance of organs, may form coagula or clots. These will enter into the consideration of the individual diseases which involve hemorrhage into the different situations just named. But coagulation within the vascular system may be briefly considered in this connexion.

Coagulation may take place during life in the cavities of the heart and in the vessels. Certain of the concretions or vegetations, so called, which are found on the valves and at the orifices of the heart, consist of fibrin deposited, not exuded; in other words, they are small coagula derived from the blood within the cavities. This takes place when the surface at certain points is roughened by the exudation of lymph, or by the deposit of atheroma or calcareous matter. Perhaps it may occur without any previous alteration when the blood is surcharged with fibrin, as in cases of acute articular rheumatism. It occurs in endocarditis, being due in part to the roughening of the membrane by exudation, and in part to the excess of fibrin in the blood. These small coagulated deposits are found in the left cavities of the heart especially, since inflammation and valvular lesions are of much more frequent occurrence in these than in the right cavities, and arterial blood contains more fibrin than venous blood.

The fibrin deposited in the manner just stated may accumulate so as to form masses as large as a pea or bean or even a filbert. They occasion obstruction in proportion to their volume and weight, and they are liable to be torn off by the current of blood, and carried into the circulation. They constitute then *emboli*, or plugs, which carried along the arterial branches with the flow of blood, at length reach a situation where the size of the vessel prevents their passage. Arrested at this situation they obstruct the flow of blood, and may thus give rise to pathological effects dependent on the sudden interruption of the circulation in the parts to which the obstructed vessel is distributed. Much attention of late years has been directed to this source of arterial obstructions, called embolia or embolism. Apoplectic seizures and paralysis are sometimes attributable to an obstruction of an important cerebral artery thus produced. Emboli or plugs have been found after death fixed in arteries of the brain and in other situations, which have been found to be similar, as regards their gross and microscopical characters, to co-existing fibrinous deposits within the cavities of the heart.

Coagula in greater or less abundance are usually found in the cavities of the heart after death. These have been called "death polypi;" they are found especially in

the right cavities, because the blood accumulates in greater quantity in these cavities. These coagula are in general formed either after death or during the act of dying, but they may be formed during the progress of diseases, and a sudden and unexpectedly fatal termination in certain cases is due to their formation. The accumulation of blood in the right cavities in some cases in which the heart becomes largely dilated may lead to coagulation, and sudden death occur in consequence. So, when the action of the heart is nearly, or for a brief period quite suspended in syncope, this may sometimes occur. It is in this way that Prof. Meigs explains certain cases of sudden death occurring after parturition. The occurrence is a species of accident which may take place in various diseases which may involve over-accumulation of blood in the heart-cavities, weakness of the ventricular contraction, an overplus of fibrin, or a condition of the blood favoring coagulation of the fibrin. In pneumonia it occurs not very infrequently, owing to the high degree of hyperinosis, and the obstruction to the pulmonary circulation.

Can the coagula found in the cavities of the heart under the circumstances just stated be discriminated from those found after death or during the act of dying? The loose, friable, dark coagula so often found are post-mortem formations. And if the fibrin be isolated, but soft, not adherent, not closely intertwined with the papillary muscles and tendinous cords, it may have coagulated during the last moments of life. But if the fibrin be isolated from the red globules, dense, adherent, or closely intertwined with the papillary muscles and tendinous cords, the coagulation has probably taken place at a period more or less remote from the act of dying, and the fatal termination may be attributable to it. The sudden occurrence during the progress of a disease, more especially pneumonia, of great irregularity and feebleness of the heart's action, with dyspnoea, oppression, anxiety, death taking place after the lapse of a few hours from the notable change in the symptoms, and no other cause for the change being apparent, should lead to a strong suspicion of the occurrence of this accident.

The liability to this accident in pneumonia and other diseases, suggests, of course, the inquiry whether measures to guard against its occurrence are available. Why the fibrin retains the liquid state within the vascular system has long been a mooted and obscure question in physiology. Recently Dr. Richardson, of London, has endeavored by a large number of ingenious experiments to show that it is due to the presence of ammonia in the blood. Accepting this explanation as probably true, ammonia is now frequently given as a remedy with a view to maintain the liquidity of the fibrin in the blood, in cases in which there may be reason to fear the formation of heart-clots.

Coagulation may take place in the blood-vessels. It occurs in aneurismal dilatation of arteries. The sac in aneurism is frequently lined with successive layers of dense fibrin. The coagulation is here due to accumulation and stasis of blood. It occurs in phlebitis. The inflammation occasions a coagulum either from the direct action of the inflammatory products on the blood or by altering the condition of the interior surface of the vein, or by both effects combined. The inflamed vein is frequently filled by a clot, and may be permanently obliterated. This occurs in the affection known as phlegmasia dolens. Coagulation in the cerebral sinuses is supposed to be a cause of serious disorder of the intra-cranial circulation in some cases, giving rise to hæmorrhage and serous effusion. Coagulation in the small vessels of the lower extremities is an element in dry gangrene or gangrena senilis, due to weakened circulation and a morbid condition of the arteries. In cachectic persons coagulation may take place in the deep-rooted veins of the extremities, or within the pelvis, without phlebitis. The pressure of a tumor upon a vein may cause stasis sufficient to give rise to coagulation. The immediate effect of coagulation in a vessel is obstruction to the circulation according to the size and situation of the vessel. And as consequences of this obstruction arise œdema, coldness,

weakness of the parts, wasting, and sometimes gangrene. The presence of the clot sometimes excites local inflammation and suppuration, acting like a foreign substance. In some instances the formation of a coagulum leading to obliteration of a vein may be useful, as in cases of varicose, hæmorrhoids, and varicose veins of the extremities. Coagula forming in veins either from phlebitis, or other causes, may be carried along with the current of blood, or fragments may be separated and transported, and, passing into the right cavities of the heart, be driven into the pulmonary artery, and give rise to obstruction of this vessel or its branches. Sudden death may be produced by a mass of fibrin sufficient to cause plugging of the pulmonary artery, and local inflammation with suppuration may occur from the presence of smaller masses in the branches of this artery. This variety of embolia has been called *thrombosis*, and the movable plugs thus derived from the veins are called *thrombi*. It will be seen that emboli found in the left cavities of the heart, or in the arteries, produce obstruction in the arterial tree of which the aorta is the trunk, while the emboli found in the veins, or thrombi, produce obstruction in the pulmonary arterial system.

Having considered the pathological relations of fibrin, I pass to the other of the two most important organic constituents of the liquor sanguinis, viz. *albumen*. This exists in the serum of the blood after the separation of fibrin. It exists normally in a liquid state. It does not, like fibrin, coagulate spontaneously, but may be coagulated by heat or the addition of mineral acids, and is then presented as a white deposit. It is found also in chyle, lymph, dropsical effusions, and in various fluids of the body. It is much more abundant in the blood than fibrin, existing in the proportion of 60 to 70 parts in 1000. The serum of the blood owes to it much of its density, which in health is represented by about 1030. Albumen is doubtless a very important constituent of the blood, but its precise physiological uses and relations are not satisfactorily ascertained. There is reason to believe that it furnishes the pabulum for the development and renewal of the organized or corpuscular constituents, and it undoubtedly constitutes the material for the nutrition of many of the tissues. It has been supposed that the fibrin is formed from the albumen. The two substances are nearly identical as regards their chemical composition.

Albumen is increased in certain diseases, viz. acute rheumatism, pneumonia, pleurisy, etc. But, with our present knowledge, it is impossible to say how much pathological importance belongs to this fact. It does not appear to be uniformly increased in inflammations as fibrin is. It has not, therefore, the same significance as a criterion of inflammation. In short, there are no known special pathological relations of an excess of albumen.

The pathological relations of an abnormal diminution of the quantity of fibrin are more apparent. This constitutes an important condition incident to affections of the kidneys, characterized by the presence of albumen in the urine, or albuminuria. This blood-constituent escaping constantly with the urine, the quantity in the blood is proportionately lessened. Hence, the density of the serum is lowered. Bright reported a case in which the specific gravity of the serum was reduced by a deficiency of albumen as low as 1013.

An important morbid effect frequently follows diminution of the albumen, and, thereby, of the density of the blood. Aqueous or serous transudation is apt to occur into the interstices of the areolar tissue, giving rise to œdema and anasarca, and into the serous cavities. It thus occasions general dropsy. This effect is doubtless in a great measure due to the diminished density of the blood-serum; it becomes unduly aqueous, and filtrates more readily through the tissues. But it is probably in a measure due to an obstruction to the free passage of the blood through the capillary vessels. Experiments have shown that the presence of fibrin and albumen in the blood facilitates its

circulation in the capillary system; hence, when the blood is deprived of a considerable portion of its albumen, it accumulates in the capillary vessels, and the increased pressure favors transudation, or dropsy.

Diminution of albumen has been observed in various cachectic affections, in some cases of inflammation, in typhus, notably in scorbutus, in puerperal fever, dysentery, etc. This condition occurs whenever the body is insufficiently nourished, either from too little or poor food, or defective appropriation from any cause; also whenever there is an abnormal expenditure of blood constituents, as in chronic diarrhoea, copious purulent discharge, etc. The loss of albumen does not bear any constant relation to the number of red globules. It is neither increased nor diminished in chlorosis or anæmia. Nor does it appear to sustain any relation to fibrin. Bleeding, which increases fibrin, appears to lessen albumen, but not in a marked degree.

Of morbid alterations of the quality of fibrin we know nothing positive. That important changes in this point of view do occur, is highly probable. But in the present state of knowledge all is conjectural. When the physiologist develops further information respecting the uses of albumen in health, its metamorphoses and its relations to other elements of the blood and to the nutrition of the tissues, the pathologist may hope to understand, better than now, to what extent and in what modes it is involved in disease.

A substance analogous to albumen distinguished by not coagulating under the influence of heat, and imperfectly with the addition of nitric acid, is called *albuminose*. It exists in the blood in the proportion of 4 to 6 parts in 1000. It is found to disappear in the course of diseases in which albumen is diminished. It has no known pathological relations.

Water constitutes a large proportion of the mass of blood, viz. about 790 to 1000 parts. Obviously a certain proportion is essential. If abnormally deficient or superabundant, evils are likely to follow, pertaining to the circulation and to changes in the blood itself. These morbid conditions of quantity are incidental to disease. It is doubtful if an excess of water ever occurs, save as an incidental morbid condition. The quantity of blood, as already stated, is probably not subject to much fluctuation. It is, however, by no means probable, as stated by Lehmann and others, that the mass is never increased nor diminished. In phthisis, and the wasting diseases, it is undoubtedly diminished; and it is probable that the amount is sometimes increased. But, as a rule, its normal fluctuations are inconsiderable. If too much liquid be ingested and absorbed, the augmented pressure within the vessels causes exhalation from the pulmonary mucous membrane, the skin, and more especially the uriniferous tubes of the kidneys, and the balance is speedily restored. On the other hand, if loss be sustained, the deficiency is speedily made good by the absorption of water. In the latter mode the blood may become unduly watery, constituting *hydræmia*. If the globules are reduced in number the space is filled with water. If albumen be drained away the serum becomes watery. Hydræmia, therefore, is a substitution of more or less of the other constituents of the blood by water, and not the blood normally constituted, plus a certain amount of water. It is thus incidental to other morbid conditions of the blood. It is doubtful if water ever remains in excess, while the other constituents continue unaffected. Deficiency of water in the blood in a notable degree, is incidental to epidemic cholera. The density of the blood in this disease is greatly increased; it becomes thick, and is with difficulty circulated.

The morbid conditions and relations of several of the most important of the constituents of the blood have now been briefly considered, to wit, the red and colorless glo-

bules, or the organized elements, the fibrin and albumen of the liquor sanguinis, carbonic acid gas and oxygen, and water. Numerous constituents yet remain to be noticed. Of these some are organic, and others inorganic, or mineral. Of the remaining organic elements, there are the fatty and extractive matters, sugar, and certain principles embraced under the head of excrementitious substances. In the next lecture I shall consider briefly these remaining constituents as arranged in the groups just named.

Original Communications.

OPERATIONS ON THE AIR-TUBE.

By CHAS. K. BRIDDON, M.D.,

SURGEON NEW YORK DISPENSARY.

In the following series cases will be found illustrating different pathological changes occurring in the air-passage, and the results obtained by operative procedures made for the relief of urgent symptoms occasioned by the same.

It will be remarked that the local lesions in all these cases were associated with, or dependent upon dyscrasies, and that in at least two classes the systemic conditions were allied in character.

In Cases I., II., III., IV., and VI., the changes were deposits of aplastic material on the free surface of the laryngo-tracheal mucous membrane. In three of these cases it was undoubtedly croupous, and although the deposit was the result of changes which had taken place in the blood, the fatal issue was as certainly induced by the mechanical impediment offered to the free admission of air into the lungs.

In Case III. the operation of tracheotomy afforded immediate and marked relief, and, but for the unfortunate accident which occurred in the obstruction of the canula by a plug of inspissated mucus, it is probable that the result would have been more fortunate. It will be noticed that in this case the operation was done early; in the others, in which the opening was made at a late stage of the disease, I do not think that any relief was afforded.

In the remaining cases of this class the exudation was diphtheritic, and the impression made upon the system was profound. Operative interference yielded no results. The medical gentleman in attendance on Case IV. informed me that after the introduction of the canula the respiration was less labored, and that in his judgment the child died of exhaustion.

The gentlemen in charge of Case VI. reported that their patient was not in any way relieved. In this case no benefit was expected to follow the operation, which was done at the urgent solicitation of the patient and his friends.

The impression made upon my mind by the study of these cases, of others of a kindred character which occurred in the practice of my friends, and my readings upon the subject, has been that operative interference is not likely to influence the result in the cases where diphtheria has invaded the air-tube, and that, to be successful in cases of croup, it must be made early, at a period of the disease when I think the conscientious surgeon will hesitate before he acts, knowing that it is in just such cases that recoveries will not infrequently occur under less harsh treatment.

In the other class represented by Cases V. and VII., the formation of an artificial opening was followed by more decisive results, though cachæmia existed in both these cases, in the one in the form of syphilis, in the other in that of leucocythæmia. The immediate danger to life was occasioned by the mechanical obstruction to respiration which existed in the neighborhood of the laryngeal aperture. In Case V. it is probable that submucous exudation took place around the necrosed laryngeal cartilages.

In Case VII. it is equally probable that the obstruction was caused by exudation of a similar character, but occasioned by contiguous cellulitis.

The reports of Cases I., II., IV., and VI. are necessarily brief. No notes were taken of the cases which were under the control of my medical friends; the other cases were reported by myself.

CASE I.—This occurred in the practice of my friend Prof. Chas. A. Budd. The patient was a boy, aged six years; he was suffering from the effects of croupous exudation in the larynx and trachea. The obstruction had already brought the patient into a condition of asphyxia, and the operation was done as a *dernier ressort*. A double canula was introduced, and the patient was left in charge of Prof. B. I did not see the patient again, but was afterwards informed by the father that the child was in no way relieved, and died in a few hours after the operation.

II.—This case occurred in dispensary practice. The patient, Michael Lynch, aged four years, was in the last stage of croup. Tracheotomy was performed, a double canula introduced, and he was left in the care of Mr. Stephen Clark (now Dr. S. Clark, U.S.V.). When I returned in two hours I found the child dead. It appears that during a paroxysm of suffocative cough the canula had become displaced, and was found afterwards lodged in the areolar spaces between the trachea and thyroid muscles.

III.—Happened in my own practice. I visited the patient, — Lynch, aged three years, on the second of January, 1861, and found him suffering with well marked symptoms of inflammatory croup; he had been troubled for several days with cough and pyrexia, and at the time I saw him, there was some, but not urgent dyspnoea, the cough was stridulous, and had the peculiar metallic tone characteristic of croup. I ordered a warm bath, and an emetic to be followed by mist, ammon. et potassæ chlor. 3d.—His symptoms were aggravated, but still not urgent; he was ordered another emetic, and continuance of the mixture. Five p. m.—I found the child still worse, his lips were livid, face bedewed with moisture, and his extremities were losing their natural temperature. I recommended the operation of tracheotomy. Six p. m.—Visited the child in company with my friend, Dr. Aigner, and several of my students. Dr. A. coincided with me as to the propriety of an operation, and it was immediately proceeded with. The trachea was opened, a double canula, both tubes well lubricated with glycerine, was introduced, and I made arrangements with my students to form relays to remain with the patient through the night; full instructions were given them as to action in emergency, and I saw the patient myself at intervals of four hours. The change which took place after the operation was very gratifying; he breathed freely; his face, no longer livid, was suffused with the ruddy glow of reaction; he eat, drank, and played with his attendants, and everything seemed to indicate a successful issue. At eight a. m., next morning, I received an urgent message, and hurrying to the bedside found my little patient dead. Mr. Geo. Badger (now Dr. Geo. Badger, doing service on David's Island), who was attending at the time, noticed a change occur in the child shortly before eight o'clock, he gasped for breath, and instinctively raised his hands towards the tube. Mr. B. immediately removed the inner canula, introduced a swab provided for the purpose, and sent for me. I reached the house within two minutes after the child had ceased to breathe. I instantly removed the outer canula, when the cause of obstruction was revealed; the extremity of the canula was blocked by an annular mass of inspissated mucus which had been detached, and in an expiration had been forced into the end of the canula, in all probability. When Mr. Badger introduced the swab he forced it from the point where it was impacted, but, of course, it would follow the removal of the swab, and regain the same position in the lesser end of the tube. After removing the outer canula I emptied the trachea of the frothy spume which it contained, by suction with the lips applied to the wound, and then I

alternated insufflation with the postural treatment; this I kept up for half an hour, when finding that both life and all hope of resuscitation had fled, I desisted.

IV.—April 19th, 1862, I was requested by Dr. Bernard Kelly, of Broome st., to open the trachea of a patient of his that was suffering from an attack of diphtheria. I found the child, aged two years and a half, almost asphyxiated, the fauces were covered with exudation, and it was evident that the larynx was also involved, though we were not able to determine how far down the tube the disease had extended. I at once proceeded to the operation, but before I had reached the trachea the child had ceased to breathe. I completed the operation as rapidly as possible, introduced a canula, and inflated the lungs with my lips applied to the opening. After a few inflations the child gasped, and respiration was restored. I advised the frequent removal of the inner canula, the occasional introduction of a few drops of glycerine, and consigned the case to the care of Dr. K. I was subsequently informed by the Doctor that the urgent symptoms of dyspnoea were entirely relieved by the operation; the child survived thirty hours, and appeared to sink from exhaustion.

V.—The history of this case will be found recorded in the proceedings of the Pathological Society, June 25th, 1862. The patient, a Frenchman, aged forty-two, had syphilitic antecedents, and at the time of the operation was dying in a condition of apnoea, caused by oedema of the glottis. The relief afforded by an artificial opening was marked, but the changes occasioned by the destructive ravages of the disease were such as did not permit the removal of the canula. The patient resumed his occupation, and continued to follow it for some months, when he began to suffer from the formation of wads of inspissated mucus, mingled with the debris of tissue. These exudations were thrown out around large masses of necrosed ossified laryngeal cartilages, which, gravitating, lodged, and formed cylindrical moulds of the larger bronchi and trachea. A subsequent operation was performed on this patient, the cavity of the larynx was exposed, and the necrosed alae were removed; the patient only survived this second operation a few days, and at the autopsy, amongst other pathological changes, the cricoid cartilage was found in a condition of necrosis.

VI.—January 15th, 1863, I was requested to meet Prof. Chas. A. Budd and Dr. Holcomb in consultation on a case of diphtheria, and was desired to come prepared to perform the operation of tracheotomy. The patient, a native of Massachusetts, aged thirty-nine years, had been attacked with the disease two days before. I found him suffering severely from urgent dyspnoea; his face was livid, surface bedewed with moisture, eyes prominent, and all his respiratory muscles were vigorously engaged in the terrible but useless efforts to expand the chest. I observed that the muscles of the neck were most active, those associated with the thoracic walls less so; in fact, the chest itself appeared to be almost motionless, and it was everywhere resonant. In the fauces were several patches of exudation, and I was shown some casts which had been expectorated in the morning, and they were the most perfect of their kind that I had ever seen; arising from a stem half an inch in diameter, they divided and subdivided dichotomously down to casts of the minuter ramifications of the tube.

The opinion was expressed that in all probability he would not be relieved by an artificial opening which would most likely be situated above the obstruction, but the patient himself and his friends desired that it should be done. For a little while after the canula was introduced it was observed that his breathing was less labored, and his countenance became less livid, but relief was of short duration; he gradually sank and died a few hours after the operation.

VII.—*Phlegmonoid Inflammation of Neck; Laryngo-Tracheotomy.*—On the fourth day of May, 1863, I was requested to visit Charles Thomas, aged 19 years, a native of this country, and printer by occupation.

Previous History.—Patient came out of Bellevue Hospital on April 28th; he had been an inmate of that institution sixty-nine days, and says that he was treated there for leucocythæmia splenica. The day he received his discharge from the hospital he was out late, and in less than twenty-four hours afterwards began to experience pain in the right side of his neck; it was accompanied by tumefaction, and both pain and swelling went on increasing up to the present date; he has not been able to sleep for several nights, and for the past two days he has not been able to separate his teeth, and has found swallowing even fluids extremely difficult.

Present Condition.—General aspect of the boy is bad; he looks as if he were the subject of some dyscrasy, though the anæmic appearance of his face is masked by the suffusion of febrile excitement; the temperature of his skin is exalted, and his pulse is accelerated.

The normal contour of the right side of the neck is obliterated by a diffuse, elastic swelling, which occupies the whole of that region, mounting over the inf. max., and passing across the mesial line in front; it does not feel like the hard, brawny swelling which is met with in the ordinary forms of sub-fascial abscess; there is an element of elasticity about it which I have not observed in the other variety, and which appears to be limited to the tissues superficial to the deep fascia. The impression conveyed to the finger is, that all the parts beneath the fascia are infiltrated with the solid products of inflammation, and at no part of the swelling could I detect fluctuation. The color of the integuments was unchanged; it was tense, white, and glistening.

I was only able to separate his jaws about a quarter of an inch, and in the glimpse that I was able to obtain of the fauces, fancied, but am not certain, that I discovered some swelling which approximated the tonsils, but there was none of the arterial injection met with in amygdalitis. 6th, p.m.—I received a pressing summons to visit the patient, who, I was informed, was suffocating. When I arrived at his house I learned that in the early part of the afternoon his breathing had become very difficult, and that he was no longer able to articulate. I found him suffering from urgent dyspnoea; the fixed condition of his jaws prevented my ascertaining the condition of his glottis, and although I could detect no fluctuation in any portion of the external swelling, I determined to make an effort to relieve him by an explorative incision into its most prominent part. The parts were incised to the extent of an inch and a half over the centre of the sterno-cleido-mastoid, the fascia was divided on a director, and a finger was introduced beneath it, in front of, and behind the posterior border of the muscle, but in no direction was I able to detect the presence of any collection of fluid; the tension of the parts separated the sides of the incision, and it was not necessary to introduce anything for that purpose.

I now directed my attention again to the fauces; by introducing a stout tablespoon I was able to separate the jaws about a quarter of an inch, and by the aid of a bad artificial light, and a clumsy assistant, I was just able to get a sight of the parts. I was in the act of depressing the dorsum of the tongue with the handle of the spoon when I saw a little stream of pus well up in the back of the throat, and in the same instant the boy jumped from the lounge and fell backwards in the agony of death from suffocation. It was evident that the pressure of the spoon handle had ruptured the walls of an abscess, and that it had either opened into his trachea or gained entrance through the natural aperture in quantity sufficient to deluge the air tube. His efforts to inspire were fearful, but they were fruitless, and whilst I was taking out my instruments and explaining in a few brief words the necessity of an immediate operation, he raised himself up, pointing towards his throat, and fell back apparently dead—lips apart and livid, features fixed and motionless. There was not a shadow of a doubt but that all respiration had ceased. Without more delay than was necessary to open the blade

of a knife I made a free incision through the infiltrated tissues in front of the windpipe, which was situated at least an inch and a half from the surface; the condition of the parts resembled that occurring in the brawny perineal swelling met with after urinary infiltration, and in the deeper portion immediately overlying the tube there was a stratum of extravasated blood. I cut right into the thyroid cartilage, and immediately heard air in small quantity pass either into or out of the chest. I could not introduce my finger into the tube, however, until I had carried the incision downwards so as to divide the crico-thyroid membrane and cricoid cartilage; when this was done the fixed muscles became suddenly and spasmodically contracted, and a pretty free inspiration was made. To my great relief I could now hear air freely entering the tube which was introduced upon removal of the finger, and the boy's features, which a moment before were fixed in the vacant stare of death, were once more lighted up with animation. The canula introduced was a double one, of large size, with a movable neck-plate; the management of it was left in charge of a trusty woman, who was directed to remove the inner one at intervals of two hours; he was also ordered to be freely supplied with diffusible stimuli and fluid nourishment. 7th.—His breathing has been free during the whole of the night, and he expresses himself as much relieved; the swelling of the neck does not appear to have at all diminished, and he still experiences the same trouble in swallowing. The inner canula has been removed, cleansed, and replaced every two hours, and before introduction each time it has been lubricated with glycerine; cataplasms of sem. lini pulv. are applied to the neck, and he is fed upon the mist. vini gallici. 8th.—General condition much improved; slept considerable through the night, and feels much refreshed this morning; he still swallows with difficulty, and, when he attempts to do so, a portion of the fluid passes through the wound in the larynx; the surface of the incision made in the side of the neck is covered by adherent exudation, but it does not as yet discharge pus; cataplasms are assiduously applied, in the hope that they may invite such discharge to this point. 9th.—Still continues to improve, takes his noggs well, and says he thinks the obstruction in his throat has diminished; neck appears less swollen, but there has been no discharge from the lateral incision. 10th.—Attention was directed to the left side of the neck. He says it is very painful, and there is some swelling over the sternal origin of the stern. cleid, and mastoid; the part is also tender, but irrespective of this he is doing well. 11th.—Swelling observed yesterday was increased, and as I detected fluctuation an incision was made which evacuated about two ounces of well elaborated pus. I removed the external canula, and found that no union had taken place in any portion of the incision made to reach the air-tube. After I had removed it I occluded the opening in the soft parts with my thumb, but as I found the voice almost inarticulate, and respiration somewhat labored, I lodged it again *in situ*, and determined to let it remain there a few days longer. 12th.—Can separate his jaws to the extent of an inch; fauces not congested or abnormal in appearance; he will not permit me to make a digital examination of his glottis. 15th.—Swelling of the right side of the neck has increased, and deep-seated fluctuation can be detected. I succeeded in establishing a communication between the site of the original wound over the mastoid and the cavity of an abscess situated beneath the deep fascia. The boy's general condition is improving in spite of this additional tax upon his system; he takes fluid nourishment in good quantity, with stimulants and supr. fer. hypophosphit. 17th.—After exploring with a probe, I found that the opening over the centre of the mastoid was not sufficiently dependent, and made another in a more favorable position. 19th.—All the swelling has disappeared, the openings are discharging freely, and he looks altogether a different being; removed outer canula for a few minutes, and found his voice and breathing decidedly improved. 21st.—Removed

both canulas, and, finding respiration unimpeded, did not replace them, but left instructions to be sent for immediately if any embarrassment occurred. 22d.—Removal of tube has caused no inconvenience; he looks very much improved, and says he can swallow much better now than when the tube was in.

After this date the boy steadily improved under the use of good diet, in combination with the administration of ferruginous and other tonics. Obliteration of the openings made in the neck was tardy; it was more than six weeks before the one in the trachea was closed; and at a later period those situated on the lateral aspect of the neck, which had degenerated into fistulous tracts, were still occasionally discharging.

DEATH RESULTING FROM THE USE OF CHLOROFORM DURING LABOR.

By O. D. POMEROY, M.D.,

OF NEW YORK.

I was called to attend Mrs. C., aged 40, in labor with her tenth child; nine children living. The pains becoming very severe I administered chloroform, avoiding a full anæsthetic effect, in the mean time labor terminating favorably. There was no cough or any unusual symptoms until the patient began to return to consciousness, a period of about half an hour from the commencement of the inhalation. She then had signs of irritation of the air passages, as evinced by a few moist rales. An opiate was administered, with the hope that this state of things would disappear; this being about 11 P.M. At ten next morning I was summoned in haste to her bedside, and found her breathing with great difficulty; mucous rales were heard throughout the lungs; pulse feeble, with other signs of sinking. Brandy was freely administered, and, after rallying a little, an emetic was given, with the view of relieving the accumulation in the bronchial tubes. It produced no effect, however, beyond a slight emesis. She died in ten or fifteen minutes after. The chloroform was obtained of a reliable druggist, and was manufactured by one of our most respectable chemists.

Upon inquiry of the manufacturers I found that a short time previous (1861) their chloroform was made by a different process, as it was found to be of greater purity. This, however, showed a tendency to decompose upon exposure to the air, giving off free chlorine. At once all in the market which could be found was recalled.

There was no post-mortem, as the friends would not have permitted it had I requested it. All the vital organs, however, seemed normal, and I was unable to assign any other cause of death but the inhalation of the chloroform.

GUNSHOT WOUND OF BRAIN.

By T. H. STILWELL, M.D.,

SURGEON IN CHARGE OF GRACE CHURCH HOSPITAL, ALEXANDRIA.

COLONEL THOMAS RUFFIN, 15th North Carolina cavalry, aged thirty-seven years, was wounded at the battle of Bristoe Station, by a musket-ball coming from before backwards, striking the skull near the apex, and plunging along the sagittal suture, a distance of four inches. The skull was bared about two inches, and both tables fractured, making an opening about one-eighth of an inch in diameter. Patient perfectly conscious, no paralysis of any muscles of the body. No pain was complained of, appetite good, pupils natural and regular. Had full power over sphincters, was perfectly conscious, bowels constipated, pulse good. Urine passed freely and voluntarily the day following his admission. Delirious during the day a few moments at a time; would attempt to raise himself from his bed, and tear dressings from head. Free evacuations of bowels, feces and urine passed voluntarily. Patient continued in this state until two minutes before death, when he commenced breathing stertorously, and died.

Post-Mortem Examination.—The whole of the vessels of the scalp much congested. There were two apertures near the apex of the skull, one about one-eighth, and the other one-quarter of an inch square, extending through both tables. Upon removing skull-cap it was found that its inner table had been shattered around the apex, about one inch and a quarter in diameter, and the pieces deep into the brain matter. Two pieces, three-quarters of an inch in diameter, embedded in the dura mater, and about two ounces of blood found in the base of the skull with cerebellum. Upon removing the dura mater found two clots of blood, about two and a half fluid drachms each, lying on the left lobe of the brain, and about three ounces of purulent mucous fluid. The brain matter of the left lobe was cut up, making an opening two inches in diameter, extending from the external opening of the wound to the left lateral ventricle, and several pieces of bone varying from one-quarter to one-eighth of an inch in diameter, found along this opening, and into the left ventricle. In the right lobe directly under the wound and on a level with the corpus callosum was found a piece of the bullet, flat, and one half of an inch in diameter, deeply imbedded, and the course from the external opening of the wound in the skull to the left ventricle was discolored.

Reports of Societies.

NEW YORK PATHOLOGICAL SOCIETY.

STATED MEETING, JUNE 24, 1863.

DR. L. A. VOSS IN THE CHAIR.

CHRONIC PNEUMONIA IN A CHILD, ENDING IN ABSCESS OF THE LUNG.

DR. KRACKOWIZER also presented the portion of a lung removed from a child twelve months old. When about seven months old, last February, the patient suffered from an attack of measles, and two months subsequently, when first seen by Dr. Krackowizer, was found suffering from pneumonia of the right lung. This condition of inflammation continued until the end of the April following, the child during all the time growing thinner and being subject to profuse perspirations. On April 18th the child vomited up a large amount of purulent matter, which was followed by a contraction of the lower portion of the right chest. There was then increased resonance on percussion all over the contracted portion, metallic tinkling, and other evidences of a large cavity. The opinion given was that a cavity in the lung had discharged itself, but on account of the contraction of the chest it was concluded that no pneumothorax existed. Dr. Jacobi, who saw the child at that time, confirmed that view. The patient lingered on until June 22d, when it died of exhaustion. There was no examination of the chest made during the last month of life, as the patient was in too feeble a condition to allow of it.

On post-mortem examination the left lung was found adherent to all parts of the pleural cavity, except at one circumscribed spot, where a collection of pus was found which communicated with the cavity in the lung tissue. Both lungs were studded throughout their whole extent with hard tubercles, as was also the case with the bronchial glands. The case was remarkable as one of pneumonia lasting such a length of time, and also interesting in respect to the question of diagnosis, it being evident that at first the abscess discharged itself through one of the bronchial tubes, and that it afterwards perforated the lung into the pleural cavity, giving rise to circumscribed empyema.

DR. NOYES presented the eyeball of a soldier, aged 20 years, who first came under his observation five days previously. The patient had been in a military hospital for some time for treatment of necrosis of the bones of the

foot, and at a certain period, which he could not designate, his eyesight became destroyed. About three weeks before presenting himself to the Eye Infirmary he stated that a white spot made its appearance on the outer surface of the right eyeball, and soon afterwards something broke inside the eye. When Dr. Noyes first saw him the lower half of the eye was inflamed; there was, however, no ecchymosis of the conjunctiva. The iris was inflamed and pushed towards the cornea. When the eyeball was directed strongly upwards a tumor was discovered on its lower portion. The conjunctiva and sclerótica had been destroyed over its most prominent portion. At that time he had not the slightest perception of light. The ophthalmoscope threw no light on the case. In the course of the next few days the symptoms became more aggravated, the size of the tumor increased, and it was decided to make an incision into its substance. This procedure was followed by no good result. Thereupon it was decided to remove the eye at once, which was done. On dissection of the eye after removal it was found that the retina had been completely separated from the choroid, and that the vitreous humor had been absorbed. The tumor was found to be connected with the choroid and sclerotic coats; and it was also evident that by inflammatory agglutination it had found its way through to the external surface of the eyeball. Upon the retina there were seen numerous white elevations, the size of a rape seed. Too hasty a microscopical examination of the tumor was made to decide upon its composition, though the appearances presented were very suspicious of cancer.

DR. SANDS thought that it was probably cancerous, from the fact that the tumor had invaded the sclerotic coat and passed through it.

INVAGINATION.

DR. JACOBI presented two specimens of invagination of the intestine. The first had the following history: It was taken from a female child, four months and a half old, who, up to five days before death, had enjoyed good health. She was then seized with diarrhoea, attended with a slight discharge of blood and some tenesmus. Subsequently vomiting came on after the taking of food. The child remained in about this condition for the succeeding four days. During that time she became somewhat emaciated, and the pulse became feeble. At first the treatment consisted of purgatives, but when the attending physician diagnosed the true nature of the case, it was changed. Dr. Jacobi saw her about this time, and made use of every means to reduce the invagination, such as holding the child by the feet, resorting to injections of warm water, and of gas, but with no avail. A tumor was at that time detected in the left inguinal region. The child died in a convulsion.

The autopsy was made sixteen hours after death. There were a few ounces of serum found in the peritoneal cavity. The invagination commenced about six inches above the anus, and measured about four or five inches in length. As was usual in cases of intussusception in early infancy, the invaginated portion commenced in the small intestine, the ileo-cæcal valve being implicated, and the whole forming a hard tumor. The upper end of the mass showed slight evidences of injection. There was present also some slight general peritonitis.

The second specimen of intussusception was taken from a child five years of age, who, during her whole lifetime, was intensely cyanotic. On the third day before her death she became soporose, and was never roused from that condition. About forty-eight hours after this symptom made its appearance she was seized with a diarrhoea, the passages consisting of serum and mucus, mixed with a very small amount of blood; at the same time she showed symptoms of tenesmus. The child had, during the last twenty hours previous to death, from ten to fifteen passages of the nature described. She vomited a few times during her illness, and died from sheer exhaustion. On

post-mortem examination the invaginated portion was found to consist of the lower portion of the small intestine, the ileo-caecal valve, the ascending, and a portion of the transverse colon. The period during which this invagination continued was about twenty hours, and in consequence of its short duration there were no symptoms of peritoneal inflammation present.

The question arose as to the possibility of this invagination being produced during the agony, but inasmuch as all the symptoms of the accident were present during life, Dr. Jacobi concluded that it was due to other causes.

The cause of the cyanosis was due to the pulmonary artery, absence of one-fifth of the septum of the ventricle.

CONGENITAL CANCEROUS CYSTIC HYGROMA.

DR. JACOBI presented a third specimen, a cancerous tumor, removed from the sacral region of an infant about sixteen months old. Dr. Jacobi saw the child when but four months old. There was then a tumor on the right gluteal region, extending over the median line a little to the left, evidently (at least in part) consisting of a cystic growth. The child was not seen by him afterwards until the post-mortem examination. The tumor had then very much increased in size. Part of the mass had undergone degeneration and suppuration; the remaining portion was made up of a number of cysts, which were filled with fluids of various consistencies, and separated from each other by pretty solid tissue. The tumor had its origin on the anterior portion of the os coccyx, and thus the lower portion of the sacrum, and this bone, were pushed upwards, and the anus was pushed forwards to that extent, that the perineum was made very short. The microscopic examination of the tissue of the tumor showed it to be cancerous. Dr. Jacobi thought that it was a case of congenital cancerous cystic hygroma, of which he had been able to find but one other case in medical literature.

MORBUS COXARIUS—NECROSIS OF HEAD OF FEMUR.

A fourth specimen was the head and neck of a femur, removed post-mortem from the body of a girl aged seven years. The patient about a year ago fell down a flight of stairs, and some time afterwards was brought to Dr. Jacobi's clinique in the first stages of hip disease. She was treated by extension, and seemed to improve for a time. A few months elapsed, and she was again brought in in the second stage of the disease. The treatment was continued, and she again seemed to recover, but was a third time brought back, when a tumor was discovered a little within the median line of the femur and about an inch below the greater trochanter. An incision was made into this swelling, and a large amount of matter evacuated. No communication could be detected into the joint. On the fourth day after the operation the child died of scarlet fever.

On post-mortem examination the head of the femur was found necrosed in several places. The cartilage of inervation was destroyed, and the acetabulum was found carious, with the exception of its anterior and lower portion.

DR. POST stated that it was remarkable that the head of the femur should be necrosed and not carious.

DR. CONANT remarked that Dr. Sayre had presented a case of morbus coxarius where the same condition of things existed.

M. TROUSSEAU has astonished the French medical men by demanding permission to retire from his clinical chair. "This professor, still so fresh in mind and body, so zealous, and devoted to the instruction of students, whose lectures are so largely attended, is, we are told, fatigued, and requires rest. His pupils, however, see things differently. A petition has been got up by them, and already covered with signatures, calling upon the minister not to accept his resignation."—*Brit. Jour.*

American Medical Times.

SATURDAY, NOVEMBER 14, 1863.

HUMANITIES AND INHUMANITIES OF WAR.

A LONDON Medical Contemporary, which frequently quotes dubious newspaper paragraphs reflecting upon our Government, or the people of the North, protests, in the name of humanity, "against a kind of warfare which no Government, claiming to be recognised amongst Christian nations, has a right to practise." The first of the "series of outrages" which has so moved the sympathies of this British philanthropist is an "order issued (at Norfolk, Va.) that no physician shall practise his profession who will not take an oath of allegiance." Though we are not acquainted with the facts upon which this order was based, we do not doubt its justice. Military necessity doubtless led to an order requiring all persons pursuing business to be loyal men, and we see no reason why medical men, as a class, should be exempt, and especially the physicians of that city. We have never heard a rumor even of unfairness in the military administration of GEN. VIELE, and were the facts known we do not believe that even an Englishman would cavil at this order.

The second outrage is stated as follows:—"The State of Virginia has an insane asylum at Williamsburgh. When that town fell into the hands of the Federals there were three hundred lunatics in the asylum. The physicians, keepers, and nurses were driven away, and the friends of the inmates forbidden to see or minister to them. The institution was placed under military rule, and the management assigned to army surgeons, with common soldiers for nurses; and word was sent that if any attack were made the 'poor lunatics' would be turned out and sent to Richmond, where was neither room nor accommodation for them." We happen to know something about this lunatic asylum and its management both by the rebels and the federals. The asylum was taken possession of during the peninsular campaign, a surgeon placed in charge, the nurses retained, and a full supply of hospital and other stores furnished. The building was also improved in its internal arrangements, and the institution was placed in a better position than previously. During the following season the rebels made a raid upon the town of Williamsburgh, sacked the asylum, stripping it of every movable article, taking with them also all the old nurses. The "poor lunatics" were left in a perfectly destitute condition. Word was then sent that if this act were repeated the inmates would also be sent to Richmond. The asylum was reprovided and has remained unmolested from that time, and we have the testimony of DR. NICHOLS of the National Insane Asylum, and DR. GRAY of the New York State Asylum, who have, at different times, been directed by the President to inspect the institution, that it is well provided and well managed. This charge of inhumanity against our Government, couched in high-sounding phrases, and seasoned with complacent reflections upon the humane character of the English wars, has not the least foundation in fact. War is essentially the very perfection of barbarism. It aims at the destruction of human life by such means as almost neces-

sarily cause the largest amount of human misery. Its weapons are designed to destroy life, or, failing in this, to maim, and bruise, and cripple an antagonist. And if an enemy cannot be destroyed outright, he may be stabbed, or burnt, or drowned. War respects neither life nor property. In every aspect in which we may view it war is cruelly and relentlessly destructive of everything held sacred among men. All history teaches us the truth of these statements. Large armies will commit acts of vandalism, however strict be their discipline. Governments must also enforce decrees that on their face are repugnant to the popular sentiment in times of peace. England stands forth as the highest type of civilization, and yet no nation ever exhibited more of the ferocity of war. The American revolution was marked by acts of inhumanity which still make the young tremble when they listen to their repetition. In Boston, in New York, and in every city where they enforced military rule, they disregarded the amenities of civilized life. The medical profession, like other kinds of business, was placed under the most rigid surveillance, and no one could practise but the loyal. We need not allude to the sufferings in the prison ships, to the horrible atrocities practised by savages upon defenceless women and children under direction and pay of the English, to the cruelties of the East Indian wars, or to the extermination of entire towns in Ireland by English armies. These facts are among the records of history. They teach the lesson that war, however civilized the people engaged, is destructive of the material interests of man.

And yet war may have a coloring of humanity. Justice and mercy may go hand in hand upon the same bloody battle-field. An erring son may raise his parricidal arm against him to whom he owes implicit obedience, and the same parental hand that inflicts the corrective chastisement may bind up the wounds which itself had made. So, near the scene of carnage where hosts contend against hosts, animated by the most fiendish and cruel passions, we may find the gentlest ministrations of mercy. Friend and foe alike receive succor. The same hands administer to the relief of every one who requires aid.

The war on the part of our Government is the first in the history of civilization where every possible effort was put forth to mitigate its horrors. While our armies are pushed forward to the speedy accomplishment of their great work, they are supported and encouraged at every step by the medical department bearing all that is necessary to their comfort and health. In the terrible struggle on the battle-field the wounded receive early and tender care. Nor is this solicitude confined to the soldier of the Government; the wounded rebel is equally well provided for. In the hospital the loyal and disloyal are placed side by side, and share the same attentions. The Sanitary and Christian Commissions are great auxiliary bodies in the care of the sick, and are the direct medium through which the people communicate with the army. Neither of these associations distinguishes between the Northern and Southern soldier.

But we need not dwell on these facts, so often presented in these pages. War in its mildest state is the greatest scourge that can be inflicted upon any people. But we believe it is conducted in this country as humanely as it is possible under any circumstances. Life is sacrificed on an enormous scale, but not more than in other wars of equal magnitude. Acts of individual barbarism are committed,

but they are the exception, and have no sanction from Government. History will not fail, we are persuaded, to give to our Government due praise for its persistent efforts to mitigate the rigors of war.

THE WEEK.

The success of the Sanitary Commission in the Western Department has been most encouraging. Large and most timely supplies have been sent to the different armies, and on the great battle-fields the Commission has been foremost in supplying aid. Much of the efficiency of the Commission in this department is due to the energy and executive ability of Dr. NEWBERRY. He has so organized and distributed labor as to have active co-operation at any desirable point. The people do not seem to tire in their efforts to sustain this noble charity.

In his address before the Social Science Association, Dr. CHRISTISON contended that there was not sufficient evidence to prove that deficient drainage produced fevers. Foul air may predispose to fever, but the exciting cause must be sought elsewhere. The following, in regard to the prevalence of tubercular disease, is important:—

"Philanthropists and legislators, in dealing with the unhealthiness of towns, have, until lately, had chiefly to do with epidemic diseases as their main source of excessive mortality. But it is apparent that tubercular diseases are a still more serious source of destruction to the well-being of a great city. It is also most probable that the abatement of their ravages will need a different description of measures from those which have been proved to be serviceable against diseases of the epidemic class. The discovery of the necessary measures is a duty which it peculiarly becomes this association to press upon the Government of the country, and also upon the great, the wealthy, and especially those whose business of life it is to amass wealth through the labor of the working classes, and whose requirements have occasioned the concentration of the people in overgrown towns, with all its concomitant evils."

Reviews.

TRANSACTIONS OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK, FOR THE YEAR 1863. Albany: 1863.

(Concluded from page 221.)

ARTICLE VII.—*A New Operation for Artificial Hip-Joint in Bony Ankylosis. Illustrated by Two Cases.* By LEWIS A. SAYRE, M.D., Professor Orthopædic Surgery, Bellevue Hospital Medical College, and Surgeon to Bellevue Hospital.—The first case is thus stated: Ankylosis of both hip-joints—tenotomy and brisement force in one, and in the other excision of semicircular segment of bone above trochanter minor—recovery with artificial joint.—The patient was a native of Lexington, Ky., age 26, and presented the following condition. The left thigh was immovably fixed at nearly a right angle with the pelvis, by long cementation or true ankylosis. The right was very firmly attached to an angle not quite so acute, and by a very careful examination I thought some slight motion could be detected which indicated that the attachments were fibrous in character, or at most were asterphytes only, and external to the joint, and that there was no agglutination between the femoral head and the acetabulum, whereas the opposite side seemed perfectly cemented together. He could not walk, except by whirling himself in semicircles, first on one

leg as a pivot, and then the other—or else by swinging himself on his crutches from the axilla. In order to get both feet upon the ground at the same time, his back was curved inward very much at the sacro-lumbar junction, the left knee flexed at an angle of about 45 degrees with the thigh, and the right side of the pelvis was some inches higher than the left. He could only sit by assuming a most awkward posture, half reclining on his side upon a couch or sofa; and in lying down was curled up either on one side or the other, or if upon his back he had to be supported by pillows under his knees, and under the lumbar vertebrae. In fact, he was the most pitiable object I ever saw, and one that would excite the sympathy of any surgeon.

The following operation was performed on the right thigh: division subcutaneously of the adductor muscles, the rectus, tensor vaginae femoris, and femoral fascia of the right hip, and breaking up the adhesions by some considerable force, obtaining a very good motion to the joint. Extension was made to the limb by a weight and pulley, and the hip enveloped in cloths wet in cold water; no serious trouble followed the operation, and in six weeks he could flex and extend, ab- and adduct his right limb with considerable freedom. On the left a semicircular segment of bone above the trochanter minor was removed for the purpose of establishing a new joint. Drs. L. P. Batchelder, Woodhull, and Osborne of this city, Drs. Hooker of New Haven, Ct., Hichborne, of Mass., and Dr. James S. Green, of Elizabeth, N. J., were present at the operation.

The design of this operation was to go above the trochanter minor, so as to retain the insertion of the *peas magnus* and *iliacus-internus* muscles attached to the lower fragment, for the purpose of flexion, and by cutting out a *semicircular* piece with its concavity downward, and then rounding off the upper end of the lower section, to nearly imitate the natural joint.

Dr. Sayre states that, so far as he is informed, this is the first section of the femur at this point; but he has overlooked the operation of Dr. Kearney Rogers. Dr. Sayre's case was entirely successful. Four months after the operation the patient could go up and down the steps without any difficulty; could stand on either leg without either crutch or cane; could take a step with either foot twenty-seven inches, and when he supported his body on his crutches, could straddle his legs thirty-six inches apart. He could cross either leg over the other below the knee without assistance, but could not cross them upon the thigh.

The second case was one of ankylosis of left hip, section of elliptical segment of femur above trochanter minor—recovery, with false joint and good motion.—The patient was a lady, aged 24, who had suffered from hip-joint disease six years before, the disease terminating in ankylosis. The following was her condition at the time of the operation: "In the erect posture, the heel of the left foot was ten and a half inches from the floor, and on the right side of the right leg. In attempting to walk, it was brought to the floor, still on the right side of the opposite limb, or cross-legged; and was made to reach the floor by a remarkable curvature forward of the lumbar portion of the spinal column; but walking was attended with great fatigue, and a peculiar dull pain in the lumbar region. Urination produced constant excoriation of the limbs, requiring great care and trouble in drawing a handkerchief or soft rag between the closely compressed thighs, to keep them clean or comfortable. Several efforts were made to insert a catheter, in order that the urine might be led off without irritating her limbs; but it was impossible to insert the finger so as to reach the orifice of the urethra, either from the anterior or posterior position, although every effort was made, and with great perseverance." The same operation was performed as in the former case, and with similar results. This patient died of an intercurrent disease before the cure was entirely complete. An autopsy revealed a false joint at the seat of the operation, having many of the elements of a natural joint.

ARTICLE VIII.—Section 1. *Correspondence and Report to Wm. A. Hammond, Surgeon-General U.S.A., including Experiences in the Peninsular Campaign.* Section 2. *General Report to E. D. Morgan, Governor of the State of New York.* Section 3. *Resection of Joints and Conservative Surgery.* By JOHN SWINBURNE, M.D.—The two first sections of Dr. Swinburne's paper are already familiar to the readers of the *MEDICAL TIMES*, and we shall pass them over. The section on resections of joints and conservative surgery is an able defence of exsections as opposed to amputation, and a judicious discrimination of the rules that should be observed in the selection of cases and in performing the operation. We most heartily concur in the opinions put forward, and can only hope that they will be widely circulated in the army, where they must be productive of good results. The simple truth seems to be, that in wounds of the upper extremities amputation should rarely be performed. Nothing but life can compensate the loss of the arm. Without the overpowering weight of statistics which Dr. Swinburne brings to his aid we should be prepared to accept his arguments as conclusive.

ARTICLE IX.—*Fractures of the Cranium*, by FREDERICK HYDE, M.D., of Cortlandville, N.Y.—Dr. Hyde reports seventeen cases of fracture of the cranium with the following results:—Whole number of cases seventeen, of which ten recovered, one with impaired intellect. The remainder were fatal. In seven of the cases, from moderate to extensive lesion of membranes and cerebral texture existed. In three cases in which the compression was well marked with depressed bone, in which elevation was not practised, complete recovery followed. In four cases in which it became necessary to elevate depressed bone without trephining or obliterating solid bone, two recovered and two were fatal. In one instance of loss of a large bony fragment, without compression, complete recovery followed. Five cases in which trephining was practised, three recovered, two died. Three cases called fracture at the base of the cranium, were fatal. One case of fracture at the base of the cranium, recovered. In two cases with lesion of membranes and cerebral substance with trephining, both died. Two cases in which lesion of the dura mater and brain tissue were present, without trephining, were fatal. Two cases penetrating wound of the membranes and brain, without trephining, both recovered. One case of wound of membranes and brain, with trephining, recovered. The patients were all males between six and forty-five years old.

After narrating the cases the author discusses the vexed question of the use of the trephine, and comes to the following conclusions:—

"While the utmost precautions are to guide us in resorting to the trephine, from the results following its use in civil, private practice, we cannot so fully adopt the doctrine inculcated by some distinguished military surgeons, which would assign so large a proportion of these injuries to the expectant treatment.

"The proportion of cases in which the trephine is needed, will be small under any circumstances; for very many, which seem at the outset to show conditions needing its use, by cautious, patient manipulative trial, will be successfully met, the depressed portions sufficiently elevated, as illustrated in our group of cases.

"So, then, bearing in mind that we should exercise all possible discrimination in resorting to this operation, we, on the other hand, cannot but insist that a cautious trial for the removal of all loose spicular fragments, and blood, should it require even forceps, elevator, and trephine, would be infinitely preferable to leaving a part or all of them, which are to act as foreign agents of direct irritation upon textures of great delicacy, already under a more or less dangerous amount of lesion."

ARTICLE X.—*Case of Lithotomy*, by A. BAKER, M.D., of Norwich, Chenango county.—This case was one of stricture of the prostatic portion of the urethra; operation—weight of calculus four and a half ounces—termination favorable.

ARTICLE XI.—*Resection of Ankle Joint*, by JOHN C. JOHNSON, M.D., of Kings County.—This is a case of resection of the ankle.

"In this age of conservative surgery, when resections are so much in favor, when operations upon the largest articulations can be found in numbers in almost every periodical, those upon the ankle-joint seem strangely few. The hip, knee, and elbow are the favorite articulations for resection, while at the ankle, even when the disease is confined to the joint itself, or its immediate neighborhood, Syme's or Pirogoff's operations are resorted to, and the healthy foot sacrificed.

"So rare has been this operation at the ankle that Mr. Henry Hancock, senior surgeon to the Charing Cross Hospital, in an article in Braithwaite's *Retrospect* for January, 1860, states, 'the operation was first performed by Moran, and subsequently by Jäger and others abroad; but I believe that I am justified in stating that with the exception of those which I have done myself, there is not a single instance upon record in which excision of the ankle-joint has been performed in this country for disease.'

"In the English journals, I have not found other cases than those reported by Mr. Hancock, and in our own medical literature there is the same absence of cases. Why the solitary exception should be made of the ankle-joint, and the healthy foot sacrificed, I am at a loss to understand.

"In both Syme's and Pirogoff's operations, in addition to the loss of the foot, there is the danger of sloughing of the flaps, or of bagging of the pus, which danger does not exist in resection of the joint.

"In my own practice, an opportunity offered for an operation of this kind, though in a patient constitutionally unfavorable, and the result has been so satisfactory to the patient and surgeon, that it may not be devoid of interest to the profession. On the 26th of January, 1862, I was called to see Mr. J. C., a merchant about 45 years of age, who had received a severe injury by falling on the joint following a compound dislocation, fracture of the internal malleolus, and extensive necrosis of the tibia with profuse suppuration. The operative procedure was adapted to the condition of the parts. The result was satisfactory. The patient's improvement in general health was marked; the drain of laudable pus from the system did not produce the constitutional disturbance that the previous unhealthy discharge had. The patient progressed most favorably, with no features of unusual character. Slight portions of bone exfoliated at the points where the old abscesses had formed. About the 1st of June, the union was sufficiently firm to allow the patient to move on crutches. He can now walk with only a slight halt, and the limb is far more serviceable than any artificial one could be." The paper is illustrated with a lithograph.

ARTICLE XII.—*Hyperostosis of Lower Extremities*. By T. C. FINNELL, M.D., Surgeon to St. Vincent's Hospital, New York.—This person was 27 years old at the time of his death:—"The weight of the right lower extremity is six pounds, that of the left is five pounds, while the lower extremities of an articulated skeleton weigh only three pounds and a half." He was well formed in other respects.

ARTICLE XIII.—*Post-Pharyngeal Abscess, with Three Cases*. By HENRY S. DOWNS, M.D., New York.—Dr. Downs reports three exceedingly interesting cases of this affection, all occurring in very young children. The following case, copied by Dr. D. from Dr. Buck's notebook, presents the peculiar features of these cases:—"April 2d, 1858, I visited with Dr. Hubbard, an infant son of L. T., nine months old, who was suffering from obstructed respiration, and had but recently recovered from an attack threatening suffocation. Alarmed by the danger of this attack, the mother had sent in great haste for the doctor. The child's lips were livid, his eyes dull and expressive of exhaustion, his respiration labored, but not sonorous, his pulse accelerated, but without febrile heat. While crying, the

voice appeared unchanged, and free from hoarseness. On the right side of the neck, and below the angle of the jaw, a cluster of enlarged lymphatic glands (one of which was of the size of a large flattened nutmeg) was visible by their salient elevations above the surface. Dr. H. had already diagnosed the existence of a post-pharyngeal abscess. Inspection with the end of a spoon to depress the tongue, failed to discover anything, owing to the contraction of the velum and pillars of the palate, together with the accumulation of a viscid secretion in the fauces. With the finger, an elastic salient swelling was felt, lying upon the posterior wall of the pharynx, and situated in the median line. The upper limit of it was opposite and posterior to the base of the tongue. After two or three efforts to puncture the swelling with a sharp-pointed guarded bistoury, conducted along the left forefinger, previously introduced far back into the mouth, and placed in contact with the swelling, I at length succeeded in accomplishing the object. Instantly a gush of matter followed, that flowed from the mouth, and covered his apron. A quantity was also swallowed. The relief that followed was immediate and marked. This child had heretofore been very thriving and healthy.

"For about four weeks previous it had been ailing with its throat, without exposure to scarlet fever, or other obvious cause. There had been no croupy symptoms, and deglutition had not been much disturbed. In nursing, it would often be obliged to stop, and of late, attacks of dyspnoea had been growing more frequent and more alarming. In one of these alarming suffocative attacks, Dr. H. requested my attendance. The attack had passed off, and the child was comparatively easy at my visit. The subsequent progress of the case was favorable, and the recovery rapid and complete."

(To be Continued.)

Correspondence.

JOSEPH HYRTL,

THE ANATOMIST OF THE VIENNA MEDICAL SCHOOL.

[To the Editor of the AMERICAN MEDICAL TIMES.]

SIR:—The amphitheatre of the anatomical department of the great medical school in the Austrian capital, Vienna, was always crowded, for Professor Hyrtl's demonstrations of Topographical Anatomy, although the lecture was at an early hour, for a winter morning, between six and seven. The Lecturer came in, dressed in a very shabby attire, the main features of which were a soiled morning gown, and a stock without a collar, and pushing up his large horn spectacles, began with some humorous remark, exciting a roar all through the class; after which he would go seriously to work, although during the hour and a half many an excellent joke would be made.

There is not that profuse pictorial illustration which adds so much to anatomical demonstrations in America, but there is that which well nigh more than compensates for it: that is, a blackboard, which is kept covered with striking diagrams, drawn by the Lecturer with rapid hand, turning his head half round while at work to see if his audience be satisfied with the delineation.

Nearly all the German teachers whom I have heard cultivate the use of the blackboard to a much greater extent than is common with our instructors, and these pictures, with the artist as his own demonstrator, have an effect only to be imperfectly appreciated by those who have not been taught by them. Hyrtl's animation and wit, as displayed in his lectures, are not without their critics. I heard quite an eminent teacher speak of him as a "play actor." Be that as it may, he holds large classes, whilst Rokitsansky, with a world-wide fame, has scarcely a dozen to hear his monotonous readings from books long since given to the public.

Joseph Hyrtl, one of the professors of anatomy in the Imperial University of Vienna, born in Hungary in 1811, studied medicine in Vienna, and two years after graduation, in 1835, was elected Professor of Anatomy in the famous old university in Prague, where he remained until called to the Chair which he now occupies.

His great achievements have been in his minutely injected preparations, and those illustrating some points in comparative anatomy, especially that of the internal ear, and in his published works, which are widely known and appreciated. These last are as follows:—*Handbook of the Topographical Anatomy of the Human Body. A Text-Book of Human Anatomy. Comparative Anatomical Examinations of the Inner Ear of Man and the Mammalia*; with some other works of less importance.

Professor Hyrtl did very much to form the anatomical museums in Prague and Vienna, besides making a very large private collection, which was destroyed by soldiers, with his house, in getting at the insurgents or revolutionists in 1848. While Dr. Hyrtl was assisting in the hospital in the care of the wounded, this was done. He returned home, to find his private effects, with the result of his scientific labors, entirely destroyed. Referring to this, he said: "On seeing the ruins I went to a neighbor to borrow a shirt to replace mine soiled with blood, and a handkerchief with which to weep;" not quite as philosophical as Sir Isaac Newton, when his dog Diamond had destroyed the papers filled with the calculations of years.

The Professor has, however, a new collection, made since 1848, consisting mostly of the skeletons of fishes. This is very large, filling two large rooms, and coming from all parts of the world. He has also a large collection of the *ossicula auditus* of the mammalia. This is probably the most complete in the world, and for it he obtained a medal at the last London Exhibition. They are arranged on blackboards, and possess the highest interest to the student of comparative anatomy. One of these collections was purchased for a museum in London, the Hunterian I believe. The Professor practised surgery for a little time, but gave it up in disgust to go back to his anatomical studies, after having amputated the leg and thigh successively in a case of malignant disease, and seeing it return in the hip-joint. Hyrtl is a very industrious man, spending his days in dissections in a dirty little room just back of the amphitheatre, with a text-book of anatomy before him. I found him one day, with Gray, thus lying near the infant cadaver which he was at work upon. In person he is tall and well formed, pleasing in speech, and his writings are characterized by originality and humor, combined with lucid expression.

D. B. St. J. R.

MEDICAL SOCIETY OF THE COUNTY OF NEW YORK.

[To the Editor of the AMERICAN MEDICAL TIMES.]

Sir:—An adjourned Anniversary Meeting of the above Society was held on the second inst. at the College of Physicians and Surgeons. The attendance was very full, even better than at the preceding meeting. Among those present were some of the oldest members of the Society; those who had filled its posts of honor more than twenty years ago. After the announcement of Committees for the ensuing year, and the election of Delegates to the "American Medical Association," the re-elected President delivered a brief but felicitous address to the Society. Dr. Percy exhibited a specimen of the "*Sarracenia Purpurea*" in vigorous growth. It was obtained from the bogs in the mountains above West Point. Dr. P. stated that he should say nothing at present of its medicinal properties, but hoped at some future time to make some observations upon its uses which at present he had under consideration. It was well known to all the members present that this is the plant which has been so highly recommended for the cure of small-pox, and which was first brought before the notice of the medical profession by an Indian woman in Canada.

Dr. Elsberg presented a tongue spatula, devised by himself for the purpose of facilitating the performance of laryngoscopy and the examination of the fauces.

It having been intimated that the President had some business of a different nature to bring before the Society, which could only be done with advantage at his own house, the Society adjourned at about ten o'clock, to re-assemble at the residence of Dr. Underhill, where they were speedily enlightened as to the nature of the business which was to occupy their attention. Realizing the truth so aptly propounded two thousand years ago "*Omne tulit punctum, qui miscuit utile dulci*," the sagacious President had prepared a beautiful entertainment, which illustrated in a striking manner the correctness of this ancient theory. Several short and effective speeches were made by officers and members of the Society, in reply to sundry toasts, and so thoroughly was the "*dulce*" mixed up with the "*utile*" that a degree of enthusiasm and good fellowship was awakened, which a dozen more formal meetings might have failed to call forth. Though not strictly scientific in their character, such occasions are unquestionably very beneficial in their results.

Yours etc.,

G. F.

NEW YORK, November 7, 1868.

AN ANOMALY IN CRANIAL STRUCTURE.

[To the Editor of the AMERICAN MEDICAL TIMES.]

Sir:—Irregularities in osseous structure aside from those produced by the action of morbid causes have hitherto been confined to variations in length and thickness; *i. e.* length of the styloid process and thickness of the cranial walls. A skull now in my possession, which was obtained from a recent dissection, presents the following anomaly. On both sides of the sella turcica there is complete bony union between the anterior, middle, and posterior clinoid processes. A foramen is thus formed by the junction of the first and second, and an arch over the passage-way of the circular sinus by the union of these two with the third. A careful examination of different skulls may discover a tendency in these processes to unite, but I believe there is no case on record parallel to the above anomaly. Although devoid of that practical importance pertaining to variations of the arterial system, it may yet serve to inculcate caution in surgical operations, showing, as it does, possible variations in parts and places least expected.

W. LOCKWOOD BRADLEY,
Medical Student.

BELLEVUE HOSPITAL, November 2, 1868.

Army Medical Intelligence.

APPLICATIONS FOR ARTIFICIAL LIMBS.

This application should be made to any of the Department Medical Directors, who, if satisfied of the correctness of the claim, will order a limb from any of the manufacturers who are authorized to supply such limbs. The selection of the manufacturer is left to the applicant.

Proof must be inclosed that the applicant was an enlisted man at the time of losing the limb, and that the limb was lost in the line of duty. This proof, if he is still in service, will consist of certificates from the commanding officer, surgeon-in-charge, or any commissioned officer personally cognizant of the facts of the case. If discharged from the service, his discharge papers must be submitted for examination, with his own affidavit of the time, place, and manner of losing the limb, and, if possible, the certificate of his former commanding officer, or surgeon-in-charge.

The discharge papers will be returned to him.

Instructions as to the measurements of the limb will be forwarded by the manufacturer to the applicant.

Soldiers are not allowed to purchase an artificial limb and receive the commutation value thereof in money, nor will any money so expended be refunded out of the Government appropriation.

Commissioned officers are not entitled to the benefits of the provision made by Congress for supplying "Artificial Limbs for Soldiers."

The following are the manufacturers who are authorized to supply limbs:—Douglas Bly, New York, Rochester, and Cincinnati; E. D. Hudson, New York; Frank B. Palmer, New York, Philadelphia; B. W. Jewett, Washington, D.C.; Chas. Stafford, Chicago; H. A. Gildea, Philadelphia.

The following are the stations of the various Medical Directors to whom the applications should be made:—New York city, Surgeon C. McDougall, U.S.A.; Philadelphia, Pa., J. Campbell, U.S.A.; Baltimore, Md., Jos. Simpson, U.S.A.; Washington, D. C., R. O. Abbott, U.S.A.; Cincinnati, Ohio, W. S. King, U.S.A.; Chicago, Ill., J. B. Porter, U.S.A.; St. Louis, Mo., M. Mills, U.S.A.; New Orleans, La., R. H. Alexander, U.S.A.; Louisville, Ky., G. G. Shumard, U.S.A.

GENERAL ORDERS, NO. 351.

WAR DEPARTMENT, ADJUTANT-GENERAL'S OFFICE.
WASHINGTON, D. C., Oct. 29, 1863.

The employment of women nurses in the U. S. General Hospitals will in future be strictly governed by the following rules:—

1. Persons approved by Miss Dix, or her authorized agents, will receive from her, or them, "certificates of approval," which must be countersigned by Medical Directors upon their assignment to duty as nurses within their Departments.

2. Assignments of "women nurses" to duty in General Hospitals will only be made upon application by the surgeons in charge, through Medical Directors, to Miss Dix or her agents, for the number they require, not exceeding one to every thirty beds.

3. No females, except Hospital Matrons, will be employed in General Hospitals, or, after December 31, 1863, borne upon the Muster and Pay Rolls, without such certificate of approval and regular assignment, unless specially appointed by the Surgeon-General.

4. Women nurses, while on duty in General Hospitals, are under the exclusive control of the senior medical officer, who will direct their several duties, and may be discharged by him when considered supernumerary, or for incompetency, insubordination, or violation of his orders. Such discharge, with the reasons therefor, being endorsed upon the certificate, will be at once returned to Miss Dix.

By order of the Secretary of War:

F. D. TOWNSEND,
Assistant Adjutant-General.

ORDERS, CHANGES, &c.

Surgeon Bernard Beust, U.S.V., has been relieved from duty in the Department of the South, and will report in person without delay to the General Commanding the Department of the Monongahela, to relieve Assist.-Surgeon J. C. McKee, U.S.A.

Assist.-Surgeon McKee, on being relieved, will report in person to the Surgeon-General in this city, for assignment to duty in the Judiciary Square Hospital.

Surgeon A. E. Stocker, U.S.V., will proceed without delay to Key West, Florida, and report to the Commanding Officer of the United States forces at that place.

Assist.-Surgeon Albert Hartsuff, U.S.A., has been relieved from duty in Washington, D.C., and will repair without delay to Pensacola, Florida, and report in person to the Commanding Officer, United States forces, at that place, for duty.

Surgeon William Hayes, U.S.V., will immediately return to Harper's Ferry, Va., and resume his duties as Medical Director, 1st Division, and report by letter to the Surgeon-General, U.S.A., by what authority he left the Department of Western Virginia.

Leave of absence for sixty days, with permission to visit Washington, D.C., has been granted to Medical Inspector Keeney, U.S.A.

Leave of absence for fifteen days has been granted to Surgeon E. F. Bates, U.S.V.

Surgeon C. A. Robertson, 159th N. Y. Vols., having tendered his resignation, has been honorably discharged the service of the United States, on account of physical disability.

Medical News.

The work of DR. BUMSTEAD on Veneral is about to be honored with a translation into Italian.

DR. J. FOSTER JENKINS has been appointed General Secretary of the Sanitary Commission, and will remain in New York.

DR. B. HOWARD, Assist. Surg. U.S. Army, lately on duty in the army of the Potomac, is on sick leave in New York.

DR. H. S. HEWITT, Surg. U.S. Army, has returned from the army of Gen. Grant, and is at present at Bridgeport, Ct.

Two operations for lithotomy were performed at Bellevue Hospital, on Saturday, Nov. 6th: one by Prof. J. R. Wood, and the other by Prof. W. Parker.

MAISONNEUVE is recommending the treatment of hydrocele by the introduction of a probe charged with nitrate of silver, through the canula into the sac, a plan of treatment adopted by Dr. Willard Parker, of this city, several years ago.

FORMULA for the Capsules of Balsam of Copaiba and Oil of Cubebs, as prepared by E. Quenu. Each capsule contains 9 grains of pure Para balsam and 1 grain of essence of cubebs, which represents 13 grains of cubebs berry. The envelope or capsule is made according to the formula in the U. S. Dispensatory.

DR. WM. H. CHURCH, Surg. Vols., has resigned his position in the army, and returned to the practice of his profession in New York city. During his term of service, Dr. C. was Medical Director of Gen. Burnside's army, both in North Carolina and in the West. He accompanied Gen. Burnside in his expedition to East Tennessee, and was finally compelled to resign on account of ill health.

THE *San Francisco Med. and Surg. Jour.* announces the death of Dr. Gray:—"It is with feelings of deep regret that we perform the painful duty of announcing the death of our late distinguished confrère, Dr. Henry Martyn Gray, who died at his residence in this city, at half-past four o'clock on Thursday morning, 24th inst., aged forty-two years.

"Called from a sphere of usefulness and honor while yet in the prime of life, the end of his earthly existence is justly considered a public calamity by the community in which he lived. Born in the city of New York, Dr. Gray graduated with high honors at the Geneva Medical University. He emigrated to California in 1849, and having established his residence in San Francisco, he soon won for himself a prominent position among his fellow-physicians; while by the genial qualities of his disposition, his high mental endowments, the kindness of his heart, and his numerous acts of benevolence, he surrounded himself with a large circle of warm and devoted friends among all classes of society.

"Dr. Gray occupied a high position in the Masonic fraternity, was President of the San Francisco Pioneer Association in 1861-2, and at the time of his death held the post of surgeon, with the rank of Lieutenant-Colonel, on General Allen's staff."

Dr. Gray was formerly a resident of this city, and will be remembered as an active member of medical societies.

THE *San Francisco Med. and Surg. Jour.* says:—"If we estimate our present population at 100,000, our rate of mortality has been less than 1 in 49; showing a degree of salubrity which may be advantageously compared with that of any large city in the civilized world."

THE Number of Medical Students now pursuing their studies at our metropolitan schools, is rather under the number registered in October last, and considerably under those registered in 1860, when the number reached 1230. —*Brit. Jour.*

MARRIAGES.

BARTHOLOMEW-BARTHOLOMEW.—At St. Paul's Church, Philadelphia, on the 22d ult., by the Rev. Dr. Goddard, Surgeon JOHN H. BARTHOLOMEW, U.S.A., and Miss EMMA C. BARTHOLOMEW, of Philadelphia.

DRUMMER-SPEAR.—At Newburg, N.Y., on Wednesday, November 4th, by the Rev. Dr. Spole, Dr. E. S. DRUMMER, U.S.A., to REBECCA M., eldest daughter of the officiating clergyman.

HARRIMAN-PEAK.—On Wednesday, October 14th, at Trinity Chapel, New York city, by the Rev. William S. Ludlam, HORACE M. HARRIMAN, U.S.N., and SOPHIE A. SIMMONS, adopted daughter of Dr. U. H. Peak, of Fort Howard, Wisconsin.

TICE-OLMSTEAD.—On Monday, October 5th, at the residence of the bride's parents, by the Rev. J. B. Sherrill, LEWIS TICE, M.D., and Miss RUTH A., daughter of CHAUNCEY OLMSTEAD, Esq., all of Meridian, N.Y.

WEIR-McPHERSON.—At All Saints' Church, Frederick, Md. October 5th, by the Rev. Mr. Ferryman, DR. ROBERT E. WEIR, U.S.A., and MARIN, daughter of Mr. ROBERT G. McPHERSON, of Frederick.

DEATH.

ELMER.—In Springfield, N.J., on Saturday, October 17th, DR. JOHN C. ELMER, aged 46 years.

METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK.

Abstract of the Official Report.

From the 2nd day of November to the 9th day of November, 1868.

Deaths.—Men, 115; women, 101; boys, 127; girls, 85; total, 428. Adults, 216; children, 212; males, 242; females, 186; colored, 8. Infants under two years of age, 184. Children born of native parents, 18; foreign, 173.

Among the causes of death we notice:—Apoplexy, 8; infantile convulsions, 30; croup, 29; diphtheria, 15; scarlet fever, 16; typhus and typhoid fevers, 22; consumption, 70; small-pox, 0; measles, 1; dropsy in head, 12; infantile marasmus, 38; cholera-morbus, 0; cholera infantum, 8; inflammation of brain, 10; of bowels, 11; of lungs, 84; bronchitis, 4; congestion of brain, 0; of lungs, 0; erysipelas, 2; diarrhoea and dysentery, 10; 216 deaths occurred from acute diseases, and 30 from violent causes. 266 were native, and 162 foreign; of whom 117 came from Ireland; 49 died in the City Charities; of whom 17 were in Bellevue Hospital, and 7 in the Immigrant Institution.

Abstract of the Atmospheric Record of the Eastern Dispensary, kept in the Market Building, No. 57 Essex street, New York.

Nov.	SIX A.M.				TWO P.M.				TEN P.M.						
	Minimum Temperature.	Maximum Temperature.	Evaporation Below.	Barometer.	Wind.	Minimum Temperature.	Maximum Temperature.	Evap. Below.	Barometer.	Wind.	Minimum Temperature.	Maximum Temperature.	Evap. Below.	Barometer.	Wind.
1863.	°	°				°	°				°	°			
1st.	38	59	5	30.14	N.W.	51	11	30.17		W.	46	6	30.21		N.W.
2d.	35	56	5	" 26	N.	50	9	" 27		N.E.	40	6	" 26		E.
3d.	41	46	3	" 00	S.E.	54	6	29.94		S.	47	5	31.10		N.W.
4th.	40	40	3	" 14	N.W.	46	7	30.24		W.	42	3	30.18		W.
5th.	47	50	8	" 00	"	60	5	29.71		"	46	3	29.67		S.
6th.	47	48	4	29.64	"	57	5	" 63		S.W.	47	4	29.76		W.
7th.	45	50	4	29.86	S.W.	50	"	" 83		"	45	4	29.91		S.

REMARKS.—1st and 2d. Clear with fresh wind A.M. 18d. Cloudy A.M.; clear, evening. 4th. Clear. 5th. Mostly cloudy. 6th. Variable; tempest with very light rain P.M. 7th. Mostly clear; wind fresh A.M. Rain for the week ending Oct. 31st., one-third of an inch.

SPECIAL NOTICES.

THE NEW YORK ACADEMY OF MEDICINE will hold its Regular Meeting on Wednesday Evening, November 18, at 8 o'clock.

SECTION OF THEORY AND PRACTICE AND MEDICAL PATHOLOGY OF THE NEW YORK ACADEMY OF MEDICINE.—The Regular Monthly Meeting of this Section will be held at the house of the Chairman of the Section, DR. H. D. BULKLEY, No. 42 East 22d street, on Thursday next, 19th inst., at 8 o'clock P.M.

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